C.1. General. Section C includes two categories of outcome based statements. The "Objectives" represent the outcomes for this contract. The objectives are supported by technical requirements. These requirements represent specific tasks, outcomes, and/or standards that, at a minimum, must be achieved. The purpose of this contract is to provide Managed Care Support (MCS) to the Department of Defense TRICARE program. The Managed Care Support contractor shall assist the Regional Director and Military Treatment Facility (MTF) Commander in operating an integrated health care delivery system combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical, and administrative support services to eligible beneficiaries.

C-2. Objectives.

C-2.1. Statement of Objectives. There are five objectives included in this contract. They are listed below.

Objective 1 – In partnership with the Military Health System (MHS), optimize the delivery of health care services in the direct care system (see the definition of Military Treatment Facility Optimization in the TRICARE Operations Manual, Appendix A) for all MHS beneficiaries (active duty personnel, Military Treatment Facility (MTF) enrollees, civilian network enrollees, and non-enrollees).

Objective 2 - Beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiary must be highly satisfied with each and every service provided by the contractor during each and every contact.

Objective 3 - Attain "best value health care" (See TRICARE Operations Manual, Appendix A) services in support of the MHS mission utilizing commercial practices when practical.

Objective 4 - Fully operational services and systems at the start of health care delivery. Minimal disruption to beneficiaries and MTFs.

Objective 5 - Ready access to contractor maintained data to support the Department of Defense's (DoD) financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

C-3. Documents

C-3.1. The following documents, including all changes thereto, are hereby incorporated by reference and made a part of the contract. These documents form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text.

Title 10, United States Code, Chapter 55

32 Code of Federal Regulations, Part 199

TRICARE Operations Manual (TOM) 6010.51-M, August 1, 2002

TRICARE Policy Manual (TPM) 6010.54-M, August 1, 2002

TRICARE Reimbursement Manual (TRM) 6010.55-M, August 1, 2002

TRICARE Systems Manual (TSM) 7910.1-M, August 1, 2002

C-4. Definitions. Definitions are included in Appendix A of the TRICARE Operations Manual.

C-5. Government-Furnished Property and Services. Government property furnished to the contractor for the performance of this contract includes the furnishing of telephone lines and computer drops in accordance with General Services Administration (GSA) direction. At certain MTFs, space and equipment may be provided for the TRICARE Service Center (TSC). This may include information management hardware and software to allow the contractor to access the Composite Health Care System (CHCS). Equipment at the TRICARE Service Centers is described in Attachment 8, List of Data Package Contents.

C-6. Contractor-Furnished Items. The contractor furnishes all necessary items not provided by the Government for the satisfactory performance of this contract.

C-7. Technical Requirements. The contractor must fulfill the technical requirements listed below in accomplishing the overall objectives of this contract.

C-7.1. The contractor shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers which complements the clinical services provided to MHS beneficiaries in MTFs and promotes access, quality, beneficiary satisfaction, and "best value health care" for the Government. (See the TOM, Appendix A for the definition of best value health care.)

C-7.1.1. The contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract. When this contract and the accrediting body both have standards for the same activity, the higher standard shall apply.

C-7.1.2. MTFs will only refer their TRICARE Prime enrollees to a non-network civilian provider when it is clearly in the best interest of the Government and the beneficiary, either clinically or financially. Such cases are expected to be rare. Federal health care systems (for example Veterans Administration and Indian Health Service) are excluded from this Government policy.

C-7.1.3. Provider networks for the delivery of Prime and Extra services shall be established to ensure that all access standards are met at the start of health care delivery and continuously maintained in all TRICARE Prime areas. TRICARE Prime areas are defined as a forty-mile radius around catchment areas, the designated military treatment facilities in Attachment 11, Base Realignment and Closure (BRAC) sites, and any additional Prime sites proposed by the contractor. The network must include providers that accept Medicare assignment in sufficient quantity and diversity to meet the access standards of 32 CFR 199.17 for the MHS Medicare population residing in the area.

C-7.1.4. The contractor shall inform the Government within 24 hours of any instances of network inadequacy relative to the Prime and/or Extra service areas and shall submit a corrective action plan with each notice of an instance of network inadequacy. (Network inadequacy is defined as any failure to meet the access standards.) The contractor shall respond to any inquiries from agents of the Government concerning network adequacy, including requests for information on provider turnover, from a Contracting Officer (Procuring Contracting Officer or Administrative Contracting Officer), Contracting Officer's Representative (COR), Alternate Contracting Officer's Representative (ACOR), or Regional Director. The response shall be accomplished within two business days from receipt of a request.

C-7.1.5. The contractor shall ensure that provider networks and services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities. The contractor shall also ensure that all eligible beneficiaries who live in Prime service areas have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless of such changes. MTF capabilities and capacities may change frequently over the life of the contract without prior notice. The contractor shall adjust the capabilities and capacities of the network to compensate for such changes when and where they occur over the life of the contract, including short notice of unanticipated facility expansion, provider deployment, downsizing and/or closures.

C-7.1.6. The contractor shall inform potential network providers, through network provider agreements, that they agree to being reported to the Department of Veterans Affairs (DVA) as a TRICARE network provider. The contractor shall request potential non-institutional network providers to accept requests from the DVA to provide care to veterans. The agreement will give the DVA the right to directly contact the provider and request that he/she provide care to veteran (VA) patients on a case by case basis. The TRICARE network provider is never obligated to see the VA patient, but, if seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Those providers who express a willingness to receive DVA queries as to availability shall be indicated in a readily discernable manner on all public network provider listings. (Note: Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire. When a direct contract is in place, the contractor may deviate from this section.)

C-7.1.6.1. The contractor shall inform potential network providers, through network provider agreements, that they agree to being reported to Civilian Health and Medical Program of the Veteran's Administration (CHAMPVA) as a TRICARE network provider. The contractor shall request potential network providers (individual, home health care, free-standing laboratories, and radiology only) that they accept assignment for CHAMPVA beneficiaries. The contractor shall ask all providers proposed for the network to accept

assignment (see the CHAMPVA beneficiary locations in the data package, Attachment 8). The contractor shall not make this request a condition of participating in the TRICARE network but an option. Providers need see only CHAMPVA beneficiaries

when their practice availability allows and shall not give preferential appointment scheduling to CHAMPVA over TRICARE appointments. Network providers are not required to meet access standards for CHAMPVA beneficiaries, but are encouraged to do so. The contractor shall also provide to the provider the CHAMPVA-furnished claims processing instructions (Attachment 1) on submitting CHAMPVA claims to the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) for payment. Providers at their discretion, may offer the negotiated TRICARE discount directly to CHAMPVA. For any published network provider listing, the contractor shall indicate in a readily discernable manner which providers accept CHAMPVA assignment on claims.

C-7.1.7. The contractor shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17(p)(5) are met for beneficiaries residing in a TRICARE Prime service area. These standards shall be met in a manner which achieves beneficiary satisfaction with access to network providers and services as set forth in the contract.

C-7.1.8. The contractor shall maintain an accurate, up-to-date list of network providers including their specialty, gender, work address, work fax number, and work telephone number for each service area, whether or not they are accepting new beneficiaries, and the provider's status as a member of the Reserve Component or National Guard. The contractor shall provide easy access to this list, to include making it available upon request, for all beneficiaries, providers, and Government representatives. The contractor shall, at a minimum, maintain this list in a Microsoft Excel compatible format; the contractor agrees not to claim any proprietary interest in the Microsoft Excel compatible list. For the purposes of this requirement, "up-to-date" means an electronic, paper, telephone or combination of these approaches that accurately reflects the name, specialty, gender, work address, and work telephone number of each network provider and whether or not the provider is accepting new patients. The information contained on all electronic lists shall be current within the last 30 calendar days.

C-7.1.9. The network, or networks, shall complement services provided by MTFs in the region. They shall be sufficient in number, mix, and geographic distribution of fully qualified providers to provide the full scope of benefits for which all Prime enrollees are eligible under this contract, as described in 32 CFR 199.4, 199.5, and 199.17. The contractor's provider networks shall also support the requirements of special programs described in the TRICARE Operations Manual and TRICARE Policy Manual.

C-7.1.10. As a condition of participation in the contractor's network, all providers shall submit all claims electronically. The Regional Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception.

C-7.1.11. All acute-care medical/surgical hospitals in the contractor's provider networks are encouraged to become members of the National Disaster Medical System (NDMS).

C-7.1.12. The contractor shall ensure that all network providers and their support staffs gain a sufficient understanding of applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner which promotes beneficiary satisfaction. This requirement pertains to all network providers and their staff and to TRICARE-authorized providers in the region. The contractor shall use the education material provided by the Government.

C-7.1.13. When provided by DVA, the contractor shall make available marketing and educational information on the VA and CHAMPVA at any provider briefings. [The contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The contractor is not required to, but may, brief these materials.

C-7.1.14. All network and non-network providers who provide services and receive reimbursement under this contract shall be TRICARE-authorized providers in accordance with the criteria set forth in 32 CFR 199.6. The contractor shall verify all providers' authorized status through the TRICARE Management Activity centralized TRICARE Encounter Provider Record (TEPRV) or, if not listed, shall obtain and maintain documentary evidence that the provider meets the criteria set forth in 32 CFR 199.6, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.1.15. The contractor shall ensure that no network provider requires payment from a beneficiary for any excluded or excludable service that the beneficiary received from a network provider (i.e. the beneficiary shall be held harmless) unless the beneficiary has been properly informed that the services are excludable and has agreed in advance of receiving the services, in writing, to pay for such

services. An agreement to pay must be evidenced by written records. A beneficiary who is informed that care is potentially excludable and proceeds with receiving the potentially excludable service shall not, by receiving such care, constitute an agreement to pay. General agreements to pay, such as those signed by the beneficiary at the time of admission, is not evidence that the beneficiary knew specific services were excluded or excludable.

C-7.1.16. The contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the specialty encounter 98% of the time. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax or other means with a formal written report provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated the referral within 30 calendar days. (Preferred method of delivery to MTF providers is electronic and will be addressed in the Memorandum Of Understanding (MOU)). If the accreditation standards organization has a more stringent specialty referral-reporting requirement, the contractor shall adhere to that standard.

C-7.2. The contractor shall audit two percent or ten referrals, whichever is greater, of referrals from each MTF monthly to validate the return of all required information within the standard addressed in paragraph C-7.1.16. The two percent sample shall be selected randomly. The contractor shall report the results of the audit to the Administrative Contracting Officer with a copy to the Regional Director and the MTF Commander no later than 45 calendar days following the month from which the sample was selected. The contractor shall develop and implement a corrective action plan every time the audit discloses a failure to respond within standards in more than two percent of the sample.

C-7.3. The contractor's referral management processes shall include a provision for evaluating the proposed service to determine if the type of service is a TRICARE benefit and informing the beneficiary prior to the visit in the event the requested service is not a TRICARE benefit. This shall not be a preauthorization review. Rather, this process shall be a customer service/provider relation's function providing an administrative coverage review. This service shall be accomplished for every referral received by the contractor regardless of whether it was generated by an MTF, network provider or non-network provider.

C-7.3.1. In TRICARE Prime areas that include an MTF, the MTF has the right of first refusal for all referrals and shall be addressed in the MOU. First right of refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the treatment. All electronic referrals to an MTF shall be by the appropriate HIPAA-compliant transaction.

C-7.3.2. Ninety-six percent of referrals of MHS beneficiaries, residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual. The contractor shall achieve improved performance levels related to this requirement in each contract period. The Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception.

C-7.4. For beneficiaries who are not enrolled to an MTF, the contractor shall ensure that care provided, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The contractor shall use best practices consistent with TRICARE law, regulation and policy in reviewing and approving care and establishing medical management programs to carry out this activity to the extent authorized by law. Notwithstanding the contractor's authority to utilize its best practices in managing, reviewing and authorizing health care services, the contractor shall comply with the provisions of 32 CFR 199.4 and the TRICARE Policy Manual regarding review and approval of mental health services. The contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract and shall follow all standards, rules, and procedures of the TRICARE PRO program.

C-7.5. The contractor shall establish a system that ensures that care received outside the MTF and referred by the MTF for MTF enrollees is properly entered into the contractor's claims processing system to ensure the appropriate adjudication of claims for enrollee's care. The MTF will transmit referral information in a HIPAA compliant manner. The contractor, using its authority as a Peer Review Organization, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a civilian setting that extends beyond the initial diagnosis related groups (DRG) for which the MTF authorization was issued. The contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made.

C-7.6. The contractor shall provide comprehensive, readily accessible customer services that includes multiple, contemporary avenues of access (for example, e-mail, world wide web, telephone, facsimile, et cetera) for the MHS beneficiary. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

C-7.7. The contractor shall operate a medical management program for all MHS eligible beneficiaries receiving care in the civilian sector, except as specified in Section C-7.7.1, that achieve the objectives of this contract. The contractor's medical management program must fully support the services available within the MTF.

C-7.7.1. The contractor shall operate programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which proven clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199 and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. When care occurs within an MTF, the contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The contractor shall propose medical management programs and patient selection criteria for review and approval of the Regional Administrative Contracting Officer prior to implementation and annually thereafter.

C-7.7.1.1. In cooperation with the MTF, the contractor shall coordinate the care and transfer of patients who require a transfer from one location to another. This function shall include coordination with the primary clinician at the losing and gaining sites, the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients.

C-7.8. Reserved

C-7.9. The contractor shall meet with and establish a Memorandum of Understanding with TMA Communications and Customer Service Directorate (C&CS) in accordance with the TRICARE Operations Manual, Chapter 12, Section 1. The MOU shall address all interface requirements necessary to effectively administer the program. The contractor shall partner and collaborate with C&CS on the identification and development of marketing and education materials required to support the accomplishment of the Marketing and Education Plan submitted in accordance with the TRICARE Operations Manual, Chapter 12.

C-7.10. All enrollments, re-enrollments, disenrollments, and transfers, to include enrollment activities of TRICARE Plus, shall be in accordance with the provisions of the TRICARE Operations Manual, Chapter 6 and the TRICARE Systems Manual. The contractor shall accomplish primary care manager by name assignment in accordance with the TRICARE Systems Manual.

C-7.11. The contractor shall use the TRICARE Enrollment and Disenrollment Forms,Attachments 2 and 3. The contractor shall reproduce the form as necessary to ensure ready availability to all potential enrollees. The contractor shall implement enrollment processes that take advantage of current technology while ensuring access and assistance to all beneficiaries which does not duplicate Government systems.

C-7.12. Beneficiaries choosing TRICARE Prime enrollment shall be enrolled to the MTF, on a first come, first served basis, until the enrollment capacity established by the MTF Commander is reached. The contractor shall ensure that MTF capacity is reached before beneficiaries may be enrolled to the contractor's network.

C-7.12.1. The MTF Commander, with prior notification to the Regional Director, may make exceptions to the requirement to enroll all beneficiaries to the MTF prior to enrollment to the contractor's network. Such instances should be rare and should be based on valid clinical capability to meet the individual healthcare needs of the patient.

C-7.13. The contractor shall enroll, re-enroll, disenroll, transfer enrollments, clear enrollment discrepancies, assign or change Primary Care Manager (PCM), and related functions for all active duty personnel in TRICARE Prime following the same procedures

applicable to non-active duty beneficiaries (TRICARE Operations Manual, Chapter 6). For beneficiaries returning from or transferring to OCONUS, the contractor shall follow the requirements of the TRICARE Policy Manual.

C-7.14. The contractor shall provide commercial payment methods for Prime enrollment fees that best meets the needs of beneficiaries. The contractor shall accept payment of fees by payroll allotment or electronic funds transfer from a financial institution as well as other payment types (e.g., check, credit cards) in sufficient variations to achieve beneficiary satisfaction. The contractor shall not require beneficiaries to pay an administrative fee of any kind for use of a particular payment option offered by the contractor. The contractor shall accept payment of enrollment fees on a monthly, quarterly, or annual basis. The contractor shall provide beneficiaries with written notice of a payment due in accordance with the TRICARE Operations Manual and when beneficiaries are delinquent.

C-7.15. The contractor shall ensure that enrollment on transition phase-in and transfers of enrollment, i.e., portability, as described in the TRICARE Operations Manual, Chapter 6, are accomplished in a way that allows for uninterrupted coverage for the TRICARE Prime enrollee. During transition, the incoming contractor shall enroll all TRICARE Prime beneficiaries to their assigned PCM and maintain the beneficiary's enrollment periods from the outgoing contractor. If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached.

C-7.16. The contractor shall establish a customer service presence for all MHS eligible beneficiaries, including traveling beneficiaries, at each catchment area, designated MTF in Attachment 11, Prime service area, and BRAC site either within the MTFor on the base if space is available, or if a BRAC site, at a location convenient to beneficiaries. These sites, and any other similar site established by the contractor, shall be named TRICARE Service Centers (TSCs) regardless of the extent of services offered. The data package described in Attachment 8 describes the space, if available, at each MTF. Where the space is insufficient to support all TRICARE Service Center activities, the contractor shall establish those customer service activities not available on site in a manner that is convenient to beneficiaries and provides the highest service levels. The contractor shall maintain a sufficient supply of TRICARE education and marketing materials at each TSC to adequately support information requests. When furnished by the DVA the contractor shall maintain quantities of information on VA and CHAMPVA at each TSC [the contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.]. The contractor shall have the ability to provide TSC services during periods when access to the TSC physical space is limited or terminated as a result of weather, war, security, or MTF/Base Commander's decision.

C-7.17. The contractor shall provide customer service support equal to ten person-hours per week to be used at the discretion of and for the purpose specified by the MTF Commander. Examples of possible uses of this time include in-processing briefings/enrollments, TRICARE briefings, and specialty briefings on specific components of TRICARE or focused to a specific subset of TRICARE beneficiaries. (The Regional Director may provide input for needed non MTF area activities.) This is in addition to the requirements for briefings and attendance at meetings specified in the TRICARE Operations Manual, Chapter 12.

C-7.18. The Contractor shall provide assistance in accessing information about other Department of Defense programs and applicable community/state/federal health care and related resources for all MHS eligible beneficiaries who require benefits and services beyond TRICARE. This function shall be referred to as Health Care Finder Services.

C-7.19. The contractor shall ensure that all contractor personnel working in DoD Medical Treatment Facilities meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Bloodborne Pathogens (BBP) Program requirements.

C-7.20. All customer assistance provided by telephone shall be without long distance charges to the beneficiary.

C-7.20.1. The contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff.

C-7.20.2. The contractor shall establish twenty-four hour, seven days a week, nationally accessible (to include Hawaii and Alaska) telephone service, without long distance charges, for all MHS beneficiaries, including beneficiaries travelling in the contractor's area seeking assistance in locating a network provider. This function shall be accomplished with live telephone personnel only.

C-7.21. The contractor shall establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner, and meet the functional system requirements as set forth in the technical requirements, TRICARE Operations Manual, and the TRICARE Systems Manual. The claims processing system shall be a single data base and be HIPAA compliant.

C-7.21.1. The contractor shall ensure that TRICARE claims/encounters (including adjustments) are timely and accurately adjudicated for all care provided to beneficiaries based on the timeliness and quality standards of the TRICARE Operations Manual, Chapter 1, Section 3.

C-7.21.2. The contractor shall provide data at the beneficiary, non-institutional and institutional level, with the intent of providing the Government with access to the contractor's full set of data associated with TRICARE. The data shall include, but is not limited to, data concerning the provider network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data.

C-7.21.3. Nationally recognized paper claim forms (UB-92, HCFA 1500s, and their successors) or TRICARE-specific paper claim forms (DD Form 2642) shall be accepted for processing. Standardized electronic transactions and code sets as required by the Administrative Simplification section of the Health Insurance Portability and Accountability Act (HIPAA) shall be accepted.

C-7.21.4. The contractor shall, as one means of electronic claims submission, establish and operate a system for two-way, real time interactive Internet Based Claims Processing (IBCP) by providing web based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. This IBCP system shall provide immediate eligibility verification by connectivity to DEERS and provide current deductible, Catastrophic Cap, and cost share/co-payment information to the provider on-line by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. The IBCP system shall comply with Department of Defense Information Technology Security Certification and Accreditation process (DITSCAP) and encryption requirements. The contractor shall regularly update the IBCP system to utilize newer encryption security protocols.

C-7.21.5. The contractor's claims/encounter processing system shall interface with and accurately determine eligibility and enrollment status based on the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the TRICARE Systems Manual.

C-7.21.6. The contractor's claims processing/encounter system shall accurately process claims in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.7. The contractor's claims processing/encounter system shall accurately process claims in accordance with the program authorizations (e.g., Program for Persons with Disabilities, inpatient mental health, adjunctive dental)

C-7.21.8. The contractor's claims processing/encounter system shall correctly apply deductible, co-pay/coinsurance, cost shares, catastrophic cap, and point-of-service provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, 199.17 and 199.18, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.9. The contractor's claims/encounter processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled as required by 32 CFR 199.8, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.10. Claims requiring additional information may be returned or developed for the missing information. The contractor shall ensure that all required information is requested with the initial return or development action and that no claim/encounter is returned/developed for information that could have been obtained internally or from DEERS. The contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims.

C-7.21.11. The contractor shall ensure non-network claims received more than 12 months after the date of service are denied unless the requirements contained in 32 CFR 199.7 are met. Timely filing requirements for network providers shall be governed by the network provider agreement, but shall not exceed 12 months from date of service (or discharge).

C-7.21.12. The contractor shall accurately adjudicate claims under the Program for Persons with Disabilities and the special programs listed in the TRICARE Policy Manual, TRICARE Reimbursement Manual and 32 CFR 199.5.

C-7.21.13. The contractor shall accurately identify and adjudicate claims involving third party liability (TPL) and worker's compensation (WC), as required by the TRICARE Operations Manual, Chapter 11.

C-7.21.14. The contractor shall accurately identify and adjudicate claims involving foreign claims according to the TRICARE Policy Manual. This includes claims for TRICARE/Medicare dual eligible beneficiareis receiving care in foreign locations with the exception of Puerto Rico, Guam, American Samoa, Northern Marianas and the United States Virgin Islands. In addition, the

contractor shall not process retail pharmacy claims from Puerto Rico, Guam, and the United States Virgin Islands. [South Region contractor only]

C-7.21.15. The contractor shall manage enrollments, collect premiums, accurately identify and adjudicate claims and perform all requirements involving Continued Health Care Benefit Program according to the TRICARE Policy Manual. [South Contract only]

C-7.21.16. The contractor shall accurately reimburse network providers in accordance with the payment provisions contained in the provider agreement/contract. The contractor's reimbursement to network providers shall not exceed the amount which would have been reimbursed using the TRICARE payment methodologies and limits contained in 32 CFR 199.14, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.17. The contractor shall accurately reimburse non-network provider claims in accordance with applicable statutory (Chapter 55, Title 10, United States Code) and regulatory provisions (32 CFR 199.14), and implementing instructions in the TRICARE Policy Manual and TRICARE Reimbursement Manual.

C-7.21.18. The contractor shall ensure that TRICARE Prime beneficiaries have no liability for amounts billed, except for the appropriate co-payment, for referred care, including ancillary services from a non-network provider as a result of a medical emergency or as a result of the TRICARE Prime beneficiary being referred to a non-network provider by the contractor. For example, this provision applies when a beneficiary is referred for surgery from a network surgeon in a network hospital, but the anesthesiologist is a non-network provider. Amounts paid in excess of the CHAMPUS Maximum Allowable Charge (CMAC), diagnosis related groups (DRG), or prevailing charge to non-network providers shall not be reported or used as health care costs for the purpose of the actual costs reported for health care fee determination under Section H.

C-7.22. The contractor shall provide to each beneficiary and each non-network participating provider an Explanation of Benefits (EOB) that describes the action taken on claims. The contractor may issue EOBs to network providers, as stipulated in the network provider agreement. The EOB must clearly describe the action taken on the claim or claims; provide information regarding appeal rights, including the address for filing an appeal; information on the deductible and catastrophic cap status following processing; and, sufficient information to allow a beneficiary to file a claim with a supplemental insurance carrier. The contractor shall mail the requested EOB, without charge to the beneficiary, within 5 calendar days of receiving a request (written, verbal, electronic) for an EOB from a beneficiary, regardless of their status. At the option of the providers, HIPAA-compliant electronic remittance advices shall be provided.

C-7.22.1. The contractor shall suppress EOBs in accordance with the TRICARE Operations Manual, Chapter 8.

C-7.23. The contractor shall accurately capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the provisions of the TRICARE Systems Manual and shall ensure the standards contained in this contract are achieved according to the TRICARE Operations Manual. All TED records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TRICARE Operations Manual.

C-7.23.1. The contractor shall submit information on all providers authorized by the contractor, to the TRICARE Management Activity centralized TRICARE Encounter Provider Record system in accordance with the provisions of the TRICARE Systems Manual.

C-7.24. The contractor shall establish and maintain sufficient staffing and management support to meet the requirements of this contract and comply with all management standards in the TRICARE Operations Manual, Chapter 1, Section 4.0.

C-7.24.1. The contractor shall participate in quarterly round table meetings with the Government, all other Managed Care Support contractors, and any other participants that the Government determines is necessary. The round table requires high level managerial participation from the contractors (CEOs, Medical Directors, etc.) and participation by the contractor’s technical and cost experts as determined by the agenda. The first round table will be held no later than 6 months after the start of health care delivery of the last Managed Care Support contract. The round table is tasked with reviewing current policies and procedures to determine where proven best practices from the participants’ Government and private sector operations can be implemented in the administration of TRICARE to continue TRICARE’s leading role as a world class health care delivery system.

C-7.25. The contractor shall establish and continuously operate an internal quality management/quality improvement program covering every aspect of the contractor's operation, both clinically and administratively. A copy of the documents describing the

internal quality management/quality improvement program shall be provided to the Contracting Officer in accordance with Section F, paragraph F.5. A report listing problems identified by the contractor's internal quality management/quality improvement program and the corrective actions planned/initiated shall be provided to the Contracting Officer in accordance with Section F, paragraph F.5.

The contractor shall provide a quarterly briefing in person or via video teleconference, as proposed by the contractor to the Regional Director and TMA staff on the contractor's ongoing internal quality improvement program. The contractor shall also comply with the Clinical Quality Management requirements of the TRICARE Operations Manual, Chapter 7; Attachment 10, National Quality Forum, "Serious Reportable Events in Healthcare"; and the vulnerability assessment requirements of the TRICARE Operations Manual, Chapter 1.

C-7.25.1. Annually, the Government will measure selected HEDIS-like (Health Plan Employer Data and Information Set) measures to compare the performance of the Military Health System with health plans reporting HEDIS measures. Annually, the contractor shall assist the Regional Director in evaluating the MHS' success, and in identifying the causes for successes and reasons for the MHS achieving results less than the civilian sector. Annually, the contractor shall assist the Regional Director in the development of a comprehensive plan for increasing the MHS' success in achieving HEDIS success rates when compared to the commercial sector. The contractor shall dedicate highly knowledgeable and skilled personnel to both the evaluation of performance results and the creation of plans to achieve excellence when the MHS is compared to the best commercial health plans. It is anticipated that a minimum of one FTE will be required.

C-7.26. The Government intends to establish a presence at the Prime contractor location and at each first tier subcontractor location. The Government representative(s) shall be included in all TRICARE meetings and activities related to the operation of this contract with the exception of meetings discussing the contractor's business strategy, and shall be provided every opportunity to represent the Government's interest. The Government representative shall also be provided with all management reports and plans related to the day-to-day and long-term delivery of services in conjunction with this contract. The Government representative shall not have a vote in the contractors' determinations, direct the contractors' actions, supervise contractor employees, or be assigned work by the contractors. The Government representative will be designated a Contracting Officer's Representative per Section G or I.

C-7.27. The prime contractor and each first tier subcontractor shall provide full-time office space and support services to the Government representative(s) equivalent to and in the proximity of the senior management of the contractor or first tier subcontractor. This shall include a fully-functional office including a private, lockable office; all appropriate office furnishings and supplies comparable to the senior managers of the contractor/subcontractor; a personal computer with e-mail and World Wide Web access; printer; telephone instrument with unlimited capability; and photocopy or access to photocopy equipment.

C-7.28. The contractor shall locate a senior executive with the authority to obligate the contractor's resources within the scope of this contract within a fifteen-minute drive of the TRICARE Regional Administrative Contracting Officer's office.

C-7.29. The contractor shall comply with the Appeals and Hearings Process contained in the TRICARE Operations Manual, Chapter 13.

C-7.30. The contractor shall collaborate with the Regional Director and MTF Commanders to ensure the most efficient mix of health care delivery between the MHS and the contractor's system within the area. Collaboration includes, but is not limited to, right of first refusal for referrals for all or designated specialty care, including ancillary services; Centers of Excellence (COE); and coordinated preventive health care. The Memorandum of Understanding (drafted by the contractor) between each Regional Director, MTF Commander, and the contractor shall be in writing and must be approved by the Contracting Officer and the Regional Director. The contractor shall initiate discussions related to and prepare the collaborative agreement. (See the TRICARE Operations Manual, Chapter 16)

C-7.30.1. The contractor shall develop and implement, in conjunction with each MTF and the Regional Director, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, et cetera. The documented contingency program shall be provided to the Regional Director 6 months following the start of option period one and updated annually.

C-7.31. The contractor shall participate in each MTF's Installation Level Contingency Exercise twice each year. The purpose of the exercise is to test the contingency program under a variety of situations and to provide information from which the contractor's contingency program shall be updated. The contractor shall also participate in Regionally Coordinated Table Top Contingency Exercises twice each year.

C-7.32. The contractor shall implement the contingency program at any or all locations within forty-eight (48) hours of being notified by the Regional Director that a contingency exists.

C-7.33. The contractor shall implement processes and procedures that ensure full compliance with the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities. (See http://www.hcqualitycommission.gov/.)

C-7.34. At midnight Pacific Time on the last day of health care delivery under this contract, the contractor shall assign its rights to the telephone number serving the region to the incoming MCS contractor.

C-7.35. The contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TRICARE Systems Manual and the MHS Enterprise Architecture (See http://www.hirs.osd.mil/hdp/index.html).

C-7.36. Personnel Security. The contractor shall meet the requirements of DoD 5200.2-R Appendix 6 of June 2002 (draft) for employees and subcontractor employees that require access to Government information technology (IT) systems or access to contractor/subcontractor IT systems that process DoD Sensitive But Unclassified (SBU) information and are directly connected to Government IT systems. The contractor shall not allow access unless the requirements of DoD 5200.2-R Appendix 6 of June 2002 (draft) are met. The contractor shall identify contractor and subcontractor positions that require access under these requirements at contract initiation and update whenever changes are necessary identifying the number, type, and location of the positions. The contractor shall initiate all documentation, maintain records, and make these records available to the Government if requested for all personnel (contractor or subcontractor) who must meet the requirements of DoD 5200.2-R Appendix 6 of June 2002 (draft). The contractor shall ensure that any person (contractor employee or subcontractor employee) that requires access under these requirements has had a favorable background investigation and, if not, the contractor/subcontractor shall request such a background investigation. The contractor shall coordinate with the Government on the implementation specifics not delineated in DoD 5200.2-R Appendix 6 of June 2002 (draft).

C-7.36.1. System Security. The contractor shall acquire, develop and maintain the DoD Information Technology Security Certification and Accreditation Process (DITSCAP) documentation to ensure both initial and continued DITSCAP Certification and Accreditation (C&A) for all contractor systems/networks that interconnect to DoD AISs/networks. In addition, the contractor shall modify the DITSCAP documentation as needed to address how identified security risks were addressed and mitigated. The contractor shall cooperate with and assist the Government's (MHS) DITSCAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DITSCAP C&A team schedule. The contractor shall also put in place processes that provide and ensure at least a C2 level of security protection for any contractor-owned contractor-operated (COCO) AISs/networks that process DoD SBU information. These requirements are further defined in DoD 5200.40 (DITSCAP).

C-7.36.2. The contractor shall comply with DoD Directive 8500.1, Information Assurance, Privacy Act Program Requirements (DoD 5400.11), and Personnel Security Program Requirements (5200.2-R). The contractor shall also comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS) and the published TMA implementation directions. This includes the Standards for Electronic Transactions and the Standards for Privacy of Individually Identifiable Health Information. It is expected that the contractor shall comply with all HIPAA-related rules and regulations as they are published and as TMA requirements are defined (including security standards, identifiers for providers, employers, health plans, and individuals, and standards for claims attachment transactions).

C-7.36.3. The contractor shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA rules and regulations and TMA requirements. The Standards for Electronic Transactions apply to all health plans, all health care clearinghouses, and all health care providers that electronically transmit any of the electronic transactions for which a standard has been adopted by the Secretary, HHS. Electronic transmission includes transmission using all media, even when the transmission is physically moved from one location to another using magnetic tape, disk or CD media. Transmission over the Internet, Extranet,

leased lines, dial-up lines and private networks are all included. Transmissions of covered data content via telephone conversations, fax machines, and voice response systems are not covered by the Standards for Electronic Transactions, however privacy and security requirements apply to these transmissions. Health plans and other covered entities conducting transactions through business associates must assure that the business associates comply with all HIPAA requirements that apply to the health plans or covered entities themselves.

C-7.37. The contractor shall furnish the DoD TRICARE Information Center and all Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators located in each region with read only access to claims data. The contractor shall provide training and ongoing customer support for this access.

C-7.37.1. The contractor shall provide unlimited read-only off-site electronic access to all TRICARE related data maintained by the Contractor. Minimum access shall include two authorizations at each MTF, two authorizations at each

Surgeon General's Office, two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Washington, two authorizations at TMA-Aurora, two aurthorizations for each Intermediate Command listed in Attachment 9, and authorization for each on-site Government representative. The contractor shall provide training and ongoing customer support for this access.

C-7.38. The contractor shall coordinate its activities to establish enrollment protocols to effect the optimum enrollment mix and numbers in the MTFs for beneficiaries living within TRICARE Prime areas. The contractor will follow MTF guidelines for assigning MTF PCMs.

C-7.39. The contractor shall meet with each Regional Director and each MTF in a collaborative and partnering manner to ensure balanced specialty workloads using the contractor's referral protocols with the MTF as the first referral site. The contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral.

C-7.40. The contractor shall comply with the provisions of the TRICARE Operations Manual, Chapter 7, regarding coordination and interaction with the National Quality Monitoring Contract (NQMC) contractor(s).

C-7.41. The contractor shall provide, no less than monthly, a listing of beneficiaries who have other health insurance (OHI) and the details of that insurance to the Pharmacy Data Transaction Services (PDTS) – the MHS' Pharmacy data repository – contractor. The form and transmission protocol shall be mutually agreeable to each, and approved by TMA.

C-7.42. The contractor shall provide pharmaceuticals to beneficiaries in situations where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit. Pharmaceuticals obtained by a beneficiary from a retail pharmacy, the TRICARE Mail Order Pharmacy, or from specialized pharmacies as a component of the consolidated retail pharmacy benefit are not the responsibility of the contractor.

C-7.43. The contractor shall have an active provider education program designed to enhance the provider's awareness of TRICARE requirements, to include emphasis on achieving the leading health care indicators of Healthy People 2010, and encourage participation in the program.

C-7.44. The contractor shall provide all services required by this contract in the state of Alaska in accordance with the TRICARE Operations Manual, Chapter 23. The provisions of Section H.8.l. and H.8.m. are not applicable to services rendered in the state of Alaska.

C-7.44.1. In a Memorandum of Understanding between the TRICARE Alaska Regional Office (TARO) and the Managed Care Support Contractor, the parties shall agree on how and when all requirements of the contract are phased in for services in the state of Alaska. The MOU shall be completed in accordance with Section F, paragraph F.5.b.(23).